		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042481

Facility Name: ASPEN RIDGE CARE CENTRE

Address: 2530 NORTH MONROE STREET (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (847) 875-0920 **Fax #** (847) 876-9351

IDPA ID Number: 36-4121314

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,664	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,664	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,321	885	1,358	8,564	8
9	SNF/PED					9
10	ICF	41,999	5,874	7,030	54,903	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,320	6,759	8,388	63,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 85.00%

D. How many bed-hold days during this year were paid by Public Aid?
19 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	215,765	32,607	21,578	269,950		269,950	(969)	268,981			1
2	Food Purchase		254,525		254,525		254,525	(4,616)	249,909			2
3	Housekeeping	201,616	28,024	0	229,640		229,640	7	229,647			3
4	Laundry	67,317	27,666	502	95,485		95,485	746	96,231			4
5	Heat and Other Utilities			152,377	152,377		152,377	0	152,377			5
6	Maintenance	59,177	37,644	44,794	141,615		141,615	1,916	143,531			6
7	Other (specify):*			14,628	14,628		14,628	0	14,628			7
8	**TOTAL General Services**	543,875	380,466	233,879	1,158,220		1,158,220	(2,916)	1,155,304			8
	B. Health Care and Programs											
9	Medical Director			37,200	37,200		37,200	0	37,200			9
10	Nursing and Medical Records	1,715,716	134,509	16,361	1,866,586		1,866,586	17,042	1,883,628			10
10a	Therapy	20,989		18,531	39,520		39,520	0	39,520			10a
11	Activities	102,458	6,623	3,441	112,522		112,522	73	112,595			11
12	Social Services	80,688		5,057	85,745		85,745	0	85,745			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,919,851	141,132	80,590	2,141,573		2,141,573	17,115	2,158,688			16
	C. General Administration											
17	Administrative	92,037		409,026	501,063		501,063	(387,224)	113,839			17
18	Directors Fees			0				0				18
19	Professional Services			222,620	222,620		222,620	3,153	225,773			19
20	Dues, Fees, Subscriptions & Promotions			128,710	128,710		128,710	(104,595)	24,115			20
21	Clerical & General Office Expense	92,787	31,841	54,398	179,026		179,026	114,000	293,026			21
22	Employee Benefits & Payroll Taxes			435,239	435,239		435,239	0	435,239			22
23	Inservice Training & Education			6,886	6,886		6,886	0	6,886			23
24	Travel and Seminar			736	736		736	11,864	12,600			24
25	Other Admin. Staff Transportation			5,966	5,966		5,966	0	5,966			25
26	Insurance-Prop.Liab.Malpractice			88,294	88,294		88,294	5,654	93,948			26
27	Other (specify):*			256,509	256,509		256,509	(256,509)				27
28	**TOTAL General Administration**	184,824	31,841	1,608,384	1,825,049		1,825,049	(613,657)	1,211,392			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,648,550	553,439	1,922,853	5,124,842		5,124,842	(599,458)	4,525,384			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			57,223	57,223		57,223	39,352	96,575			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			341,810	341,810		341,810	47,658	389,468			32
33	Real Estate Taxes			45,600	45,600		45,600	0	45,600			33
34	Rent-Facility & Grounds			633,000	633,000		633,000	(617,539)	15,461			34
35	Rent-Equipment & Vehicles			30,100	30,100		30,100	7,834	37,934			35
36	Other (specify):* STORAGE			1,701	1,701		1,701	0	1,701			36
37	TOTAL Ownership			1,109,434	1,109,434		1,109,434	(522,695)	586,739			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			111,996	111,996		111,996	0	111,996			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			111,996	111,996		111,996		111,996			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,648,550	553,439	3,144,283	6,346,272	0	6,346,272	(1,122,153)	5,224,119			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(33,829)	30		9
10	Interest and Other Investment Income	(927)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,616)	2		13
14	Non-Care Related Interest	(202,953)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(4,277)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,460)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,226)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(256,509)	27		24
25	Fund Raising, Advertising and Promotional	(94,410)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(10,681)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	2,126	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (609,762)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(523,256)	PG 6, 6A	34
35	Other- Attach Schedule	10,865	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (512,391)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name ASPEN RIDGE CARE CENTRE

IDH 0042481

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	(868)
2	**Other Care for Outpatients**	0	0	**Line 2**	(4,456)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	746
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	1,916
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(2,970)
9	**Non-Straightline Depreciation**	(33,329)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(927)	32	**Line 10**	7,513
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(4,616)	2	**Line 12**	0
14	**Non-Care Related Interest**	(202,953)	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	7,780
18	**Fines and Penalties**	(4,277)	21	**Line 17**	3,577
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(1,460)	20	**Line 19**	(2,126)
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(106,331)
22	**Special Legal Fees & Legal Retainers**	(2,226)	19	**Line 21**	(4,745)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	(256,589)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(94,410)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(10,681)	20	**Line 27**	(256,589)
29	**Non-Paid Workers**	0	0	**Line 28**	(365,999)
30	**Donated Goods**	0	0	**Line 29**	(361,140)
31	**Amortization Expense**	0	0	**Line 30**	(33,829)
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(969)	1	**Line 31**	0
33	PAGE 5 - LINE 35 VACATION ACCRUAL	7	3	**Line 32**	(203,880)
34	PAGE 5 - LINE 35 VACATION ACCRUAL	746	4	**Line 33**	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	(210)	6	**Line 34**	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	7,513	10	**Line 35**	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	77	11	**Line 36**	0
38	PAGE 5 - LINE 35 VACATION ACCRUAL	3,577	17	**Line 37**	(237,760)
39	PAGE 5 - LINE 35 VACATION ACCRUAL	128	21	**Line 38**	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE	2,126	6	**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(998,899)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(969)	0	0	0	0	0	0	0	0	0	0	(969)	1
2	Food Purchase	(4,616)	0	0	0	0	0	0	0	0	0	0	(4,616)	2
3	Housekeeping	7	0	0	0	0	0	0	0	0	0	0	7	3
4	Laundry	746	0	0	0	0	0	0	0	0	0	0	746	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,916	0	0	0	0	0	0	0	0	0	0	1,916	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,916)	0	0	0	0	0	0	0	0	0	0	(2,916)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	7,513	9,529	0	0	0	0	0	0	0	0	0	17,042	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	73	0	0	0	0	0	0	0	0	0	0	73	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	7,586	9,529	0	0	0	0	0	0	0	0	0	17,115	16
	C. General Administration													
17	Administrative	3,577	(390,801)	0	0	0	0	0	0	0	0	0	(387,224)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,226)	4,754	625	0	0	0	0	0	0	0	0	3,153	19
20	Fees, Subscriptions & Promotions	(106,551)	1,756	200	0	0	0	0	0	0	0	0	(104,595)	20
21	Clerical & General Office Expenses	(4,149)	118,149	0	0	0	0	0	0	0	0	0	114,000	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	11,864	0	0	0	0	0	0	0	0	0	11,864	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,654	0	0	0	0	0	0	0	0	0	5,654	26
27	Other (specify):*	(256,509)	0	0	0	0	0	0	0	0	0	0	(256,509)	27
28	**TOTAL General Administration**	(365,858)	(248,624)	825	0	0	0	0	0	0	0	0	(613,657)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(361,188)	(239,095)	825	0	0	0	0	0	0	0	0	(599,458)	29

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(33,829)	10,038	63,143	0	0	0	0	0	0	0	0	39,352	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(203,880)	0	251,538	0	0	0	0	0	0	0	0	47,658	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	15,461	(633,000)	0	0	0	0	0	0	0	0	(617,539)	34
35	Rent-Equipment & Vehicles	0	7,834	0	0	0	0	0	0	0	0	0	7,834	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(237,709)	33,333	(318,319)	0	0	0	0	0	0	0	0	(522,695)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(598,897)	(205,762)	(317,494)	0	0	0	0	0	0	0	0	(1,122,153)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe ASPEN RIDGE CARE CENTRI # 0042481 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6I | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, I		MANAGEMENT
OWNERS		NURSING HOMES		DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT, IL	
				LANDMARK PROPERTIES		REAL ESTATE
					ROSEMONT, IL	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	10 NURSING	$	FHC ENTERPRISES INC		$ 9,529	$ 9,529	1	9529
2	V	17 ADMINISTRATIVE	409,026	MIC BELLOWS OWNS 42.5% OF THIS FACILIT		38,225	(390,801)	2	-390801
3	V	19 PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISE		4,754	4,754	3	4754
4	V	20 DUES & SUBSCRIPTIONS		" "		1,756	1,756	4	1756
5	V	21 CLERICAL		" "		118,149	118,149	5	118149
6	V	24 TRAVEL		" "		11,864	11,864	6	11864
7	V	26 INSURANCE		" "		5,654	5,654	7	5654
8	V	28 DEPRECIATION		" "		10,038	10,038	8	10038
9	V	34 RENT		" "		15,461	15,461	9	15461
10	V	25 RENT/EQUIPMENT & VEH		" "		7,834	7,834	10	7834
11	V							11	
12	V							12	
13	V							13	
14	Total		$ 409,026			$ 283,264	$ * (385,762)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	RENT	$ 633,000	LANDMARK PROPERTIES		$	$ (633,000)	15	-633000
16	V	19	OTHER PROFESSIONAL		" "		625	625	16	625
17	V	30	DEPRECIATION - BLDG/IMP		" "		48,370	48,370	17	48370
18	V	30	DEPRECIATION - EQUIP/FURN		" "		14,773	14,773	18	14773
19	V	32	INTEREST - MTG		" "		248,538	248,538	19	248538
20	V	32	AMORTIZATION - MTG COST		" "		3,000	3,000	20	3000
21	V	20	LICENSES & PERMITS		" "		200	200	21	200
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 633,000			$ 315,506	$ * (317,494)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHEL BELLOWS	MNGMT CNSLT.	ADMIN.		SEE ATTACHED	2.92	8.51	SALARY	18,225	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,225		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 9,529	63,467	$ 9,529	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,966	18,225	63,467	18,225	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	480,456	10	35,987		63,467	4,754	3
4	20	DUES AND SUBSCRIPTION	PATIENT DAYS	480,456	10	13,291		63,467	1,756	4
5	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	81,167	63,467	98,040	5
6	21	CLERICAL	DIRECT COSTS	1	1	20,109	20,109	1	20,109	6
7	24	TRAVEL	PATIENT DAYS	480,456	10	89,811		63,467	11,864	7
8	26	INSURANCE	PATIENT DAYS	480,456	10	42,804		63,467	5,654	8
9	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987		63,467	10,038	9
10	34	RENT	PATIENT DAYS	480,456	10	117,045		63,467	15,461	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305		63,467	7,834	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,406,625	$ 129,030		$ 203,264	25

Print Preview

Print Page 8A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - LANDMARK PROPERTIES						$	$			$	1
2	AMERICAN NATIONAL BANK		X	MORTGAGE	VARIES	02/97	3,150,000	3,050,264		PRIME+	248,538	2
3	LOAN COSTS			LOAN COSTS				3,250			3,000	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK			WORKING CAPITAL	VARIES		450,000	750,000		PRIME+	70,417	6
7												7
8	RELATED PARTIES	X		WORKING CAPITAL	VARIES		780,000	780,000			68,440	8
9	TOTAL Facility Related						$ 4,380,000	$ 4,583,514			$ 390,395	9
	B. Non-Facility Related*											
10	LANDMARK PROPERTIE	X		WORKING CAPITAL	VARIES	VARIES	840,000	2,340,000	DEMAND	PRIME+	202,953	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 840,000	$ 2,340,000			$ 202,953	14
15	TOTALS (line 9+line14)						$ 5,220,000	$ 6,923,514			$ 593,348	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	133,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	0	2
3. Under or (over) accrual (line 2 minus line 1).	$	(133,000)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	178,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	45,600	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	0	8
	1996	0	9
	1997	0	10
	1998	0	11
	1999	0	12

PREVIOUSLY OPERATED BY NOT FOR PROFIT ENTITY. STILL WAITING FOR A TAX ASSESSMENT TO BE DONE. MEANWHILE, ACCRUAL IS BASED ON OTHER SIMILAR NURSING FACILITIES IN THE AREA

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	90,679		$	1
2					2
3	TOTALS	90,679		$	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204		1996		$ 807,175	$ 29,352	27.5	$ 29,352	$	$ 117,293	4
5			1997		14,949	543	27.5	543		1,879	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	RELATED PARTY LANDMARK PROPERTIES										9
10	FIRE DOORS/ALUMINUM SCREENS			1997	3,609	131	27.5	131		459	10
11	LANDSCAPING			1997	16,142	587	27.5	587		2,054	11
12	OUTDOOR SIGNS			1997	8,110	294	27.5	294		923	12
13	KITCHEN ROMODELING-FLOORING/CONCRETE FOOTI			1998	18,381	670	27.5	670		1,667	13
14	FENCE			1998	2,350	201	15	235	34	587	14
15	ASPHALT PAVEMENT			1998	7,491	640	15	499	(141)	1,373	15
16	PAVEMENT			1999	4,975	181	27.5	181		264	16
17	INSULATING UNIT			1999	6,991	254	27.5	254		371	17
18	WALLCOVERINGS/TILES/BLOCK WALLS /CARPET			1999	126,568	4,602	27.5	4,602		6,712	18
19	AWNINGS			1999	7,939	289	27.5	289		421	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB			2000	64,400	10,733	3	10,733		10,733	20
21											21
22											22
23					ADJ. TO SL	(107)			107		23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 48,370		$ 48,370	$	$ 144,736	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 280,801	$ 55,206	$ 22,762	$ (32,444)	3-15 YRS	$ 66,249	37
38	Current Year Purchases	13,690	2,017	632	(1,385)	3-15YRS	632	38
39	Fully Depreciated Assets							39
40	RELATED PARTIES	246,017	24,811	24,811			138,045	40
41	TOTALS	$ 540,508	$ 82,034	$ 48,205	$ (33,829)		$ 204,926	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 130,404	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 96,575	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (33,829)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 349,662	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipm $ 19,423 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANG	$ 625.00	$ 10,677	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 10,677	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ___

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,943	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,219)	1,046,654		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,532		6
7	Other Prepaid Expenses	59,798		7
8	Accounts Receivable (owners or related parties)	276,957		8
9	Other(specify): EMPLOYEE LOANS	11,950		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,523,834	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	294,491		16
17	Accumulated Depreciation (book methods)	(152,398)		17
18	Deferred Charges	1,917		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 144,010	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,667,844	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 328,782	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	105,697		28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable	116,219		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,296		31
32	Accrued Real Estate Taxes(Sch.IX-B)	178,600		32
33	Accrued Interest Payable	218,823		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	3,125		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,725,542	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,516,685		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,516,685	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,242,227	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,574,383)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,667,844	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,331,954)	1
2	Restatements (describe):		2
3			3
4	ROUNDING	(1)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,331,955)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,242,428)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,242,428)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,574,383)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,101,883	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,101,883	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	927	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 927	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	VENDING COMMISSIONS	1,034	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,034	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 5,103,844	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,158,220	31
32	Health Care	2,141,573	32
33	General Administration	1,825,049	33
	B. Capital Expense		
34	Ownership	1,109,434	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	111,996	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,346,272	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,242,428)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (1,242,428)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,279	1,533	$ 35,965	$ 23.46	1
2	Assistant Director of Nursing	2,700	2,925	62,973	21.53	2
3	Registered Nurses	7,514	7,979	141,610	17.75	3
4	Licensed Practical Nurses	44,538	48,917	629,710	12.87	4
5	Nurse Aides & Orderlies	85,633	93,110	789,383	8.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,907	2,158	20,989	9.73	8
9	Activity Director	1,119	1,191	15,448	12.97	9
10	Activity Assistants	8,090	8,740	87,010	9.96	10
11	Social Service Workers	6,399	6,947	80,688	11.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,767	2,984	46,201	15.48	14
15	Cook Helpers/Assistants	23,359	24,742	169,564	6.85	15
16	Dishwashers					16
17	Maintenance Workers	4,103	4,361	59,177	13.57	17
18	Housekeepers	22,436	24,497	201,616	8.23	18
19	Laundry	8,807	10,513	67,317	6.40	19
20	Administrator	2,050	2,425	92,037	37.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,664	8,379	92,787	11.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,513	6,039	56,075	9.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,878	257,440	$ 2,648,550 *	$ 10.29	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	328	$ 21,524	1-3	35
36	Medical Director	360	37,200	9-3	36
37	Medical Records Consultant	60	2,160	10-3	37
38	Nurse Consultant	245	7,883	10-3	38
39	Pharmacist Consultant	168	1,200	10-3	39
40	Physical Therapy Consultant	186	10,264	10a-3	40
41	Occupational Therapy Consulta	138	7,788	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	50	479	10a-3	43
44	Activity Consultant	36	3,441	11-3	44
45	Social Service Consultant	36	5,057	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,607	$ 96,996		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA TRUDEAU	ADMIN		$ 75,376
KRISTI RUDERMAN	ADMIN.		16,661
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,037

B. Administrative - Other

Description	Amount
	$
FIRST HEALTHCARE - MANAGEMENT FEE	409,026
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 409,026

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		222,620
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 222,620

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,779
Unemployment Compensation Insurance	82,756
FICA Taxes	203,944
Employee Health Insurance	81,286
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	1,198
EMPLOYEE BENEFITS-OTHER	14,753
EMPLOYEE PHYSICAL EXAMS	8,523
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 435,239

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,978
Health Care Worker Background Chec	1,080
(Indicate # of checks perform 45)	
ADV & PROMO/MARKETING	105,091
DUES & SUBSCRIPTIONS	10,513
LICENSES & PERMITS	388
TRUST FEES, CONTRIBUTIONS,etc.	1,460
RELATED PARTY	1,956
LESS TRUST FEES, CONTRIB, etc.	(1,460)
Less: Public Relations Expense	( )
Non-allowable advertising	(94,410)
Yellow page advertising	(10,681)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,115

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	736
RELATED PARTY	11,864
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,600

**See instructions.

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Facility Name & ID Num ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1997	$ 7,729	3	$ 1,288	$ 2,576	$ 2,576	$ 1,289	$	$	$	$	$
2	PAINT/DECORATI	1998	1,614	3		269	538	538	269				
3	PAINT/DECORATI	1999	9,491	3			1,582	3,164	3,164	1,581			
4	PAINT/DECORATI	2000	3,437	3				572	1,146	1,146	573		
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,271		$ 1,288	$ 2,845	$ 4,696	$ 5,563	$ 4,579	$ 2,727	$ 573	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost rep **YES**
If YES, give association name and amo **ILLINOIS HEALTHCARE ASSOC. $8808**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this per **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. **4,453** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangeme **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. **111,996**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Secti **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and pati **5%**
d. Have vehicle usage logs been maintair **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repc **YES**
Attach invoices and a summary of services for all architect and appraisal fees

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Facility Name & ID Number ASPEN RIDGE CARE CENTRE #0042481 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	21524	
	REPAIRS & MAINTENANCE		54	
			0	21578
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		502	
			0	502
5	HEAT & OTHER UTILITIES			
	GAS HEAT		55515	
	ELECTRICITY		69609	
	WATER		24938	
	CABLE TV - LOBBY		2315	
			0	152377
6	MAINTENANCE			
	GROUNDS MAINTENANCE		7985	
	PAINTING & DECORATING		3437	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12724	
	ELEVATOR MAINTENANCE & REPAIR		7527	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7116	
	FIRE SERVICE		2172	
	DEFERRED MAINTENANCE		3833	
			0	
			0	44794
7	OTHER			
	SCAVENGER		14628	
	SECURITY SERVICE		0	14628
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	37200	37200

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		5118	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTA	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	2160	
	PHARMACY CONSULTANT	XVIII B39	1200	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	7883	
			0	
			0	16361
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	10264	
	OCCUPATIONAL THERAPY CONSUL	XVIII B41	7788	
	SPEECH THERAPY CONSULTANT	XVIII B43	479	
	RESPIRATORY CONSULTANT	XVIII B42	0	18531
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	3441	
			0	3441
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	5057	
			0	5057
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0